BENEFIT PLAN

Prepared Exclusively For
School for Children with Hidden Intelligence

Open Access Managed Choice

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

aetna℠

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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-02 NJ)*

Aetna is pleased to provide you with this *Booklet-Certificate*. Your *Booklet-Certificate* (which includes the *Schedule of Benefits* and any amendments or riders), describes what the plan covers and how benefits are paid for that coverage.

The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* (certificate) under the group policy issued as follows:

Group Policyholder:	School for Children with Hidden Intelligence
Group Policy Number:	GP-477744
Effective Date:	January 1, 2014
Issue Date:	April 15, 2014
Booklet-Certificate Number:	1

This certificate supersedes all certificates describing similar coverage that **Aetna** previously issued to you. This certificate is subject to the laws of the State of New Jersey.

Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-005-02 NJ)*

No benefits are covered under this *Booklet-Certificate* in the absence of payment of current premiums by the Group Policyholder subject to the *Grace Period* provision and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

Except as provided for under the sections *Termination of Coverage (Extension of Benefits)* and *Continuation of Coverage,* this plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury** or **illness** that occurred, began or existed while coverage was in effect.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* if the service or supply is furnished on or after the effective date of the plan modification.

Coverage for You and Your Dependents *(GR-9N-02-005-02 NJ)*

Health Expense Coverage *(GR-9N-02-020-01 NJ)*

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Only **non-occupational injuries** and **non-occupational illnesses** are covered. Conditions that are related to the complications of pregnancy will be covered under this plan.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services *(GR-9N-02-020-01 NJ)*

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class *(GR-9N-29-005-02)*

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

Probationary Period *(GR-9N-29-005-02)*

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you complete 90 days of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the plan's probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse/civil union partner; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children
To be eligible, a dependent child must be:

- Under 26 years of age; or
- Unmarried or not in a domestic or civil union partnership and age 26 but under age 31, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.
- Newborn children from the moment of birth; however if payment of premium is required to provide coverage for the newborn child, **Aetna** may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue beyond the 31 day period.

* Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 6-18 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Children of **civil union partners**;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N 29-015-02)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment *(GR-9N 29-015-HRPA NJ)*

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing (if the health insurer requires the written statement at the time and gives you notice of the requirement), at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - the employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - cessation of a dependent's status as an eligible dependent as such is defined under this Plan; or
  - you or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You will need to enroll yourself or a dependent for coverage within 31 days of when other **creditable coverage** ends. Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse/civil union partner or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins *(GR-9N-29-025-02 NJ)*

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage *(GR-9N 29-025-02)*

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions.

Dependents' coverage will be effective:

- In the case of marriage, on the date of the marriage;
- In the case of civil union, on the date of the civil union;
- In the case of a newborn, on the date of birth;
- In the case of adoption, on the date of the child's adoption or placement for adoption;
- In the case of court ordered coverage of a spouse/**civil union partner** or child, on the date specified in the court order;
- In the case of loss of COBRA coverage under another plan, on the date the COBRA coverage ends; and
- In the case of loss of coverage for other reasons, the date on which the applicable life event occurs.

If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

How Your Medical Plan Works

(GR-9N-S-08-005-04 NJ)

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Common Terms *(GR-9N-S-08-010-01 NJ)*

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Gatekeeper PPO Medical Plan *(GR-9N 08-020-01 NJ)*

This Preferred Provider Organization (PPO) medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your PPO plan, you can directly access any **physician** or **hospital** (**network** or **out-of-network**) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers**.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions* and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This PPO plan provides access to covered benefits through a network of health care providers and facilities. These **network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**. This PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles**, **copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

Some services and supplies may only be covered through **network providers**. Refer to the covered benefits within the *What the Plan Covers* section, and your *Schedule of Benefits* to determine if any services are limited to **network** coverage only.

Your out-of-pocket costs may vary between **network** and **out-of-network** benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

To better understand the choices that you have with your plan, please carefully review the following information.

Continuity of Care

If your health care provider stops participation with **Aetna** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the heath professional's ability to practice, **Aetna** will continue coverage at the **network** benefit level for an ongoing course of treatment with your current health care provider during a transitional period. Coverage shall continue for up to four months from the provider termination date with **Aetna**, in cases where it is **medically necessary** for you to continue treatment with the terminated provider, except as set forth below:

- In the case of pregnancy, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the insured up to six weeks after delivery; or
- In the case of post-operative care, coverage of services by the terminated provider shall continue for a period of up to six months; or
- In the case of oncological treatment, coverage of services by the terminated provider shall continue for a period of up to one year; or
- In the case of psychiatric treatment, coverage of services by the terminated provider shall continue for a period of up to one year.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this Booklet-Certificate.

Coverage will be provided for new enrollees to continue an ongoing course of treatment with a current health care provider for a transitional period of up to ninety (90) days from the effective date of enrollment. If you have entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. The coverage will be authorized by **Aetna** for the transitional period only if the health care provider agrees:

- to accept reimbursement at the **negotiated charge** established by **Aetna** prior to the start of the transitional period as payment in full;
- to adhere to quality standards and to provide medical information related to such care; and
- to adhere to **Aetna**'s policies and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this Booklet-Certificate.

How Your Gatekeeper PPO Medical Plan Works *(GR-9N 08-030-01-NJ)*

Accessing Network Providers and Benefits *(GR-9N 08-030-01-NJ)*

The Primary Care Physician:

You are encouraged to select a **Primary Care Physician (PCP)** from **Aetna**'s network of providers. Each covered family member should select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of **network providers** in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a

printed copy of the provider directory through your employer or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, pediatrician or gynecologist. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or they may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** in the **network** for covered services and supplies under this Booklet-Certificate. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

(GR-9N 08-035 01 NJ)

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits *(GR-9N-08-040-01 NJ)*

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and facilities. You can change your **PCP** at anytime.
- If a covered health care service is not available from a **network provider** or facility in your area and you have selected a **PCP**, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a **referral** from **Aetna**, you will receive the network level of benefits.
- If a service you need is covered under the plan but not available from a **network provider** or **hospital** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider**'s failure to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- You will not have to submit medical claims for treatment received from **network providers** and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** and **copayments**, if any.

You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits *(GR-9N 08-045-01-NJ)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Expense Provisions* section and the *Schedule of Benefits*.

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense,** incurred from a **network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers.**

- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Coinsurance Provisions* within the *Expense Provisions* section for information on the specific limits that apply to your plan. Refer to your *Schedule of Benefits* for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or Sch*edule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible**, **copayment**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits *(GR-9N 08-045-02-NJ)*

You have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered benefits. Your out-of-pocket costs, such as **deductibles** and **coinsurance**, are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Aetna** will only pay up to the **recognized charge**.

- You select a health care provider or facility for covered benefits.
- **Precertification** is necessary for certain services. When you receive services from an **out-of-network provider**, you are responsible for requesting the necessary **precertification** from **Aetna**. Your provider may **precertify** your treatment for you, however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your medical expenses are not **precertified** by **Aetna**, the benefit payable will be significantly reduced. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied. **Precertification** is not required for medical emergency or **urgent care** claims.
- When you use **physicians** and **hospitals** that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required of you by your plan.
- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider.** This will not apply to emergency and urgent care services.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note
Failure to request **precertification** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section of this Booklet-Certificate for information on how to **precertify** and the **precertification** penalty.

Cost Sharing for Out-of-Network Benefits *(GR-9N 08-045-01-NJ)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Expense Provisions* section and the *Schedule of Benefits*.

- You must satisfy any **deductibles** before the plan begins to pay benefits.

- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to *Coinsurance Provisions* within the *Expense Provisions* section for information on what expenses do not apply to the limit. Refer to your *Schedule of Benefits* for specific dollar amounts.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

Understanding Precertification *(GR-9N 08-060-01-NJ)*

Precertification

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to request **precertification** from **Aetna** for any services or supplies on the **precertification** list that follows. **Aetna** will reduce benefits by the **precertification** penalty shown in the *Schedule of Benefits* with respect to charges for treatment, services and supplies which have not been precertified by **Aetna** provided that benefits would otherwise be payable under this Booklet-Certificate. If your medical expenses are not **precertified** by **Aetna,** the benefit payable will be significantly reduced. The list of services requiring **precertification** can be found in the *Services and Supplies Which Require Precertification* section, which follows. Refer to your *Schedule of Benefits* for the **precertification** penalty amount.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for requesting **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to

receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To request **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For a **medical emergency** or **urgent care admission**:	You do not need to call for **precertification**. However, please call your **Primary Care Physician** or Member Services to report your admission.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled, to request **precertification**.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Complaint and Appeals Health Amendment included with this Booklet-Certificate.

Services and Supplies Which Require Precertification *(GR-9N 08-065-01)*

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice** facility
- Outpatient **hospice care**
- **Stays** in a **residential treatment facility** for treatment of mental illness, alcoholism or drug abuse treatment
- **Home health care**
- Private duty nursing care

How Failure to Precertify Affects Your Benefits *(GR-9N 08-070-01-NJ)*

A **precertification** penalty will be applied to the benefits paid if you fail to request a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for requesting the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has requested **precertification** from **Aetna**. If your medical expenses are not **precertified** by **Aetna,** the benefit will be significantly reduced.

Emergency and Urgent Care *(GR-9N-27-005-01 NJ)*

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent care condition**.

In Case of a Medical Emergency

Coverage is provided for treatment of an **emergency medical condition**.

(GR-9N-27-005-01 NJ)

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

(GR-9N-27-005-01 NJ)

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

In Case of an Urgent Condition *(GR-9N-27-010-01 NJ)*

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **PCP**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Care Condition*(GR-9N-27-010-01 NJ)*

The plan will pay for the services of an **urgent care provider** to evaluate and treat an **urgent care condition**.

Your coverage includes:

- Use of emergency room facilities when **network** urgent care facilities are not in the service area and you cannot reasonably wait to visit your **physician**;
- Use of urgent care facilities;
- **Physician** services;
- Nursing services; and
- Staff radiologists and pathologists services.

Non-Urgent Care*(GR-9N-27-010-01 NJ)*

If you seek care from an **urgent care provider** for a non-**urgent condition**, the plan will not cover the expenses you incur.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition *(GR-9N-27-010-01 NJ)*

Follow-up care is not considered an emergency or **urgent care condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**. If you seek follow-up care from a **network provider** who is not your **PCP**, you will need to secure a referral from your **PCP** to minimize your out-of-pocket expenses.

(GR-9N-27-010-01 NJ)

You may use an **out-of-network provider** for your follow-up care. You will be subject to the applicable **deductible**, **copayment and coinsurance** that apply to **out-of-network** expenses, which may result in higher out-of-pocket costs to you.

Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements for Coverage *(GR-9N 09-005 01 NJ)*

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:

   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet-Certificate for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

(GR-9N-27-005-01 NJ)

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   - In accordance with generally accepted standards of medical practice;
   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   - Not primarily for the convenience of the patient, **physician** or other health care provider;
   - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

(GR-9N S-11-005-01 NJ)

Gatekeeper PPO Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Wellness Benefits

This section on Wellness describes the **covered expenses** for services and supplies provided when you are well. Refer to the *Schedule of Benefits* for the applicable maximum benefits and frequency limits that apply to these services, if not shown below.

Health Wellness Program
Covered expenses incurred in a Health Promotion Program through Health Wellness visits and counseling for the following tests and services:

- For all persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, blood cholesterol level, or alternatively, low-density lipoprotein (LDL) level and blood high density lipoprotein (HDL) level;
- For all persons 35 years of age or older, a glaucoma eye test every five years;
- For all persons 40 years of age or older, an annual stool examination for presence of blood;
- For all persons 45 years of age or older, a left-sided colon examination of 35 or 60 centimeters every five years;
- For all women 20 years of age or older, a pap smear;
- For all women 40 years of age or older, a mammogram examination. For a more detailed benefit, see the section titled Routine Cancer Screening: Routine Mammography;
- For all adults, recommended immunizations; and
- For persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunizations practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

If a **physician** or provider recommends that it would be medically appropriate for you to receive a different schedule of tests and services than that provided for this section, **Aetna** shall provide payment for the tests and services actually provided, within the limits of the amounts shown in the *Schedule of Benefits*.

These benefits will be subject to age, family history and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to you, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
- the state laws and regulations that govern the Group Policy.

Adult Routine Physical Visits

The Adult Routine Physical Visit coverage is in addition to the Health Wellness Program benefit.

Covered expenses include charges made by your **primary care physician** for visits for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

For covered adults of less than 40 years of age, 1 visit every 2 years; 40 or more years of age but less than 65 years of age, 1 visit every 2 years; and for covered adults 65 years of age or older, 1 visit every year:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

These benefits will be subject to age, family history and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to you, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
- the state laws and regulations that govern the Group Policy.

Well Child Visits

Covered expenses include charges made by your **primary care physician** for visits for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

For your dependent children:

- 7 exams in the first 12 months of life;
- 3 exams in the second 12 months of life;
- 3 exams in the third 12 months of life;
- 1 exam per year thereafter.

These benefits will be subject to age, family history and frequency guidelines. The guidelines will be determined by applying the more generous rules, as they apply to you, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
- the state laws and regulations that govern the Group Policy.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Childhood Immunizations, Screening and Treatment for Lead Poisoning
The Childhood Immunizations, Screening and Treatment for Lead Poisoning coverage is in addition to the Health Wellness Program benefit. **Covered expenses** include charges made by your **primary care physician** for childhood immunizations, screening and treatment for lead poisoning as follows:

- Blood screenings by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing, as specified by the New Jersey Department of Health and Senior Services, and medical evaluation and any necessary medical follow-up treatment for lead poisoned children.
- All childhood immunizations as recommended by the Advisory Committee on Immunizations Practices of the United States Public Health Service and the Department of Banking and Insurance.
- Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Routine Cancer Screenings

Routine Mammography

- Age 35 through 39, one baseline mammogram;
- Age 40 and older, one routine mammogram every year;
- In the case of a woman who is under 40 years of age and has a family history of breast cancer or other cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Routine Pap Smears
Include a routine Pap smear, including an initial Pap smear and any confirmatory test when **medically necessary** and as ordered by your **physician** and includes all laboratory costs associated with the initial Pap smear and any such confirmatory test.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Routine Gynecological Visits
1 visit every 12 months.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Routine Prostate Cancer Screening
To include an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 35-50 and over who are asymptomatic and for men age 35-40 and over with a family history of prostate cancer or other prostate cancer risk.

Covered at 100%, not subject to a deductible, copayment, or coinsurance.

Colorectal Cancer and Adenomatous Polyps Screening Benefits
For persons age 35-50 years of age or older and persons of any age who are considered to be at High Risk for Colorectal Cancer, the screening at regular intervals includes the following:

- Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer; and
- Annual immunochemical-based fecal occult blood test (FIT) with high test sensitivity for cancer;
- Stool DNA (sDNA) test with high test sensitivity for cancer;
- Flexible sigmoidoscopy every 5 years;
- Colonoscopy every 10 years;
- Double Contrast Barium Enema every 5 years;
- Computed tomography colonography (virtual colonoscopy) every 5 years;
- Any combination of the screening tests above; or
- The most reliable medically recognized screening tests available.

The method and frequency of screening to be utilized will be in accordance with the most recent published guidelines of the American Cancer Society and as determined medically necessary by your Physician, in consultation with you.

Coverage is provided under the same terms and conditions as any other illness under this Booklet-Certificate.

High Risk for Colorectal Cancer means a person who has:

- Family history of familial adenomatous polyposis;
- Family history of hereditary non-polyposis colon cancer;
- Chronic inflammatory bowel disease;
- Family history of breast, ovarian, endometrial, colon cancer or polyps; or
- A background, ethnicity, or lifestyle, such that the physician treating the person believes the person is at elevated risk for colorectal cancer.

Treatment of Hemophilia, Blood Products and Blood Infusion for Home Treatment
Covered expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and provide:

- Blood infusion equipment required for home treatment of routine bleeding episodes, when such home treatment program is under the supervision of a State approved hemophilia treatment center;
- Blood products which include Factor VIII, Factor IX and cryoprecipitate; and
- Blood Infusion Equipment, including syringes and needles.

Coverage is provided under the same terms and conditions as for any other illness. Please refer to the Schedule of Benefits for any applicable In-Network copayments and Out of Network deductibles and coinsurance as shown in the Schedule of Benefits.

Treatment of Hemophilia, Blood Products and Blood Infusion for Home Treatment

Covered expenses include charges incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and provide:

- Blood infusion equipment required for home treatment of routine bleeding episodes, when such home treatment program is under the supervision of a State approved hemophilia treatment center;
- Blood products which include Factor VIII, Factor IX and cryoprecipitate; and
- Blood Infusion Equipment, including syringes and needles.

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** or **coinsurance** as your cost sharing is based on the type of service provided. For any service not otherwise specifically listed on the *Schedule of Benefits*, refer to "Other Covered Expenses" on the *Schedule of Benefits* for applicable cost sharing.

Vision Care Services *(GR-9N S-11-010-01 NJ)*

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: Covered expenses include charges for a complete routine eye exam that includes refraction and glaucoma eye testing for all persons 35 years of age or older every 5 years. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Coverage is subject to the applicable deductible and coinsurance shown in the Schedule of Benefits.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Hearing Exam *(GR-9N S-11-015-01 NJ)*

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist;
- Speech-language pathologist;
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

You are responsible for In-Network copayments and Out of Network deductibles and coinsurance as shown in the Schedule of Benefits.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

These benefits will be subject to age, family history, and frequency guidelines. The guidelines will be determined by applying the more generous rules as they apply to you as set forth in:

- the most recently published preventive health care guidelines as required by the federal department of Health and Human Services, or
- the state laws and regulations that govern Group Policy.

Hearing Aid Expense

For covered dependents age 15 years or younger, **covered expenses** include the cost of a **medically necessary** hearing aid for each ear as prescribed or recommended by **covered person's physician** or audiologist up to the Hearing Aid Benefit Maximum shown on the Schedule of Benefits. Subject to any applicable **copayment**, **deductible**, and **coinsurance**, **covered expenses** also include **medically necessary** services and supplies related to the hearing aid.

Coverage is provided under the same terms and conditions as for any other condition.

Physician Services *(GR 9N S 11-35-02)*

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*. Any applicable benefit maximums and cost sharing may be different based on the type of service (for example, Prenatal Care or Allergy Treatment), type of provider, (for example, Specialist) and place of service (for example, inpatient).

Physician Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*. Cost sharing for surgical procedure may be different based on the place of service where the procedure is performed. Refer to the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable maximums.

Administration of Anesthesia

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Provision of Benefits for certain Dental Services

Coverage is provided if you are severely disabled or to a child age five or under for expenses for:

- General anesthesia and hospitalization for dental services; or
- A medical condition covered by this Booklet-Certificate which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Walk-In Clinic Visits *(GR 9N S 11-35 02)*

Covered expenses include charges made by **walk-in clinics** for:

- Services made to treat an unscheduled, non-emergency **illnesses** and **injuries**; and
- the administration of routine immunizations administered within the scope of the clinic's license.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

E-Visits

E-Visits

Covered expenses include charges made by your **primary care physician (PCP)** for a routine, non-emergency, medical consultation. You must make your E-visit through a provider who utilizes an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized internet service vendor may be found in the provider directory or online in DocFind on www.Aetna.com or by calling the member services number on your identification card.

Coverage is subject to the applicable **deductible, copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Emergency Medical Services *(GR-9N S-11-035-01 NJ)*

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment for an **emergency medical condition**.

Important Reminder
If you visit a **hospital** emergency room for a non-emergency medical condition, the **plan** will not cover your expenses, see Non-Emergency Medical Condition as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Urgent Care Services *(GR-9N S-11-035-01 NJ)*

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment of an **urgent condition**.

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, see Non-Urgent Services of an **urgent care provider** as shown in the *Schedule of Benefits*.

Diagnostic and Preoperative Testing *(GR-9N-11-080-01 NJ)*

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Your cost sharing may be different depending if services are performed at a **hospital** outpatient facility or performed at a facility other than a **hospital** outpatient facility. Please refer to the *Schedule of Benefits* for the appropriate cost sharing.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services other than diagnostic complex imaging, lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Your cost sharing may be different depending if services are performed at a **hospital** outpatient facility or performed at a facility other than a **hospital** outpatient facility. Please refer to the *Schedule of Benefits* for the appropriate cost sharing.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Limitations

The plan does not provide coverage for repeated pre-operative testing if **Aetna** determines that repetition is not **medically necessary**.

Important Reminder
- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.
- Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply.

Outpatient Surgery *(GR-9N-11-040-01 NJ)*

Outpatient Surgery

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital**; and
- The surgery is not normally performed in a **physician**'s or **dentist**'s office.

The following outpatient surgery expenses are covered:

- Services and supplies (including anesthesia) provided by the **hospital or surgery center** on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Services of another **physician** to administer a local anesthetic.
- Facility charges for office based surgery.

Also refer to Outpatient Preoperative Testing under Diagnostic and Preoperative Testing Expenses.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Your cost sharing may be different depending if the services are performed at a **physician**'s office, a **hospital** outpatient facility, a **surgery center**, or a facility other than a **hospital** outpatient facility. Please refer to the *Schedule of Benefits* for the appropriate cost sharing.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Birthing Center *(GR-9N-11-050-01 NJ)*

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Limitations

Unless specified above, not covered under this benefit are charges:

- For the services of a **physician** who renders technical assistance to the operating **physician**.
- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Maternity Expenses* for information about other **covered expenses** related to maternity care.

Inpatient Hospital Expenses *(GR-9N-11-100-01)*

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital**'s nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Inpatient Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include **hospital** charges for other services and supplies provided, such as:

- **Ambulance** services.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood derivatives, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning; and
- Anesthetics.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits.*

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Important Reminders
The Plan will only pay for nursing services provided by the **hospital** as part of its charge.

Hospital admissions need to be **precertified** by **Aetna**. Refer to Using Your Medical Plan for details about **precertification**.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**.

Maternity Expenses *(GR-9N-11-100-01)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section;
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for one post-delivery home visits by a health care provider.

Covered expenses for a **birthing center** are described under the **birthing center** section.

Covered expenses also include services and supplies provided for circumcision.

Pregnancy Complications

Covered expenses include charges made in connection with pregnancy complications of a covered female. Coverage is provided under the same terms and conditions as any **illness**. Complications of pregnancy shall mean:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy such as:
   - Acute nephritis;
   - Nephrosis;
   - Cardiac decompensation;
   - Missed abortion; and
   - Similar medical and surgical conditions of comparable severity.
   - but shall not include:
     - False labor;
     - Occasional spotting;
     - **Physician**-prescribed rest during the period of pregnancy;
     - Morning sickness;
     - Hyperemesis gravidarum;
     - Preeclampsia;
     - Similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

2. Non-elective caesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Outpatient Hospital Expenses *(GR-9N-11-100-01)*

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Home Health Care *(GR-9N S-11-055-01 NJ)*

Covered expenses include charges made by a **home health care agency** for home health care if the care:

- Starts within 10 days after discharge from a stay in a **hospital** or other inpatient facility; and
- Is for the same or related condition that caused the stay in a **hospital** or other inpatient facility.

The following services are covered when provided by a **home health care agency**. Services are only covered when rendered to you in your place of residence, under the following conditions:

- On a part-time and intermittent basis, except when full-time or 24 hour services are needed on a short-term basis;
- If continuing **hospitalization** would otherwise have been required if home health care were not provided;
- Pursuant to a **physician**'s order and under a plan of care established by the responsible **physician** in collaboration with a home health care provider, and whose plan shall be periodically reviewed and approved by said **physician**.

All care plans shall be established within 14 days following the commencement of home health care.

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care. If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge;
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care;
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker;
- Physical therapy;
- Occupational therapy;
- Nutrition services;
- Speech therapy; and
- Medical appliances and equipment, drugs and medications, laboratory services, and special meals to the extent such items and services would have been covered under the Plan if you had been in the **hospital**.

Benefits for home health care visits are payable up to the Home Health Care Maximums. Each visit by a nurse or therapist is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. Physical, speech, or occupational therapy is covered when the above home health care criteria are met and as long as a home health care benefit is provided.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable home health care benefit maximums.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Transportation; or
- Services that are **custodial care**.

Important Reminders

The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Skilled Nursing Facility *(GR-9N-11-060-02 NJ)*

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician**'s services); and
- Medical supplies.

No deductible or copayment will apply to a subsequent admission during the same convalescent period.

Important Reminder

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *Using Your Medical Plan* for details about **precertification**.

Coverage is subject to the applicable deductible, copayment and coinsurance shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Senility;
  - Mental retardation; and

- Daily **room and board** charges over the **semi private rate**.

Hospice Care *(GR-9N-S-11-070-02 NJ)*

Covered expenses include charges furnished by the following furnished for **hospice care** when given as part of a **hospice care program**.

Inpatient Hospice

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day;
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **hospice care agency**; and such agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling. This includes estate planning and the drafting of a will;
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders
Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses *(GR-9N-11-080-01 NJ)*

Acupuncture
The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Ambulance Service *(GR-9N-11-080-01 NJ)*
Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles; and
- When during a covered **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Air or Water Ambulance
Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition; and the two conditions above are met.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Limitations
Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
(GR-9N 11-171 01 NJ)

Coverage is provided for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability, the following medically necessary therapies as prescribed through a treatment plan and subject to any benefit limits reflected on the Schedule of Benefits are covered:

- occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
- physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
- speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits under the Rehabilitation Benefits Section of this Booklet-Certificate.

If a Covered Person's primary diagnosis is autism, and the Covered Person is under 21 years of age, in addition to coverage for therapy services described above, **Aetna** will also cover medically necessary behavioral interventions based upon principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan (s) must be in writing, signed by the treating physician, and must include:

- a diagnosis,
- proposed treatment, by type , frequency, and duration;
- the anticipated outcomes stated as goals; and
- the frequency by which the treatment plan will be updated.

Aetna may request additional information if necessary to determine the coverage under the plan. **Aetna** may require the submission of an updated treatment plan once every (6) months unless **Aetna** and the treating physician agree to more frequent updates.

If a Covered Person:

- is eligible for early intervention services through the New Jersey Early Intervention System;
- has been diagnosed with autism or other developmental disability; and
- receives physical therapy, occupational therapy, speech therapy, and applied behavior analysis or related structured behavior services.

The portion of the family cost share attributable to such services is a Covered Benefit. The deductible, coinsurance or copayments applicable to a **Primary Care Physician** visit for treatment of an illness or injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Developmental Disabilities provision.

Durable Medical and Surgical Equipment (DME) *(GR-9N-S-11-090-01 NJ)*

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet-Certificate. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Important Reminder
Refer to the *Glossary* additional details about **durable medical and surgical equipment**. Also refer to *Exclusions* for information about home and mobility exclusions.

Experimental or Investigational Treatment *(GR-9N-11-095-01 NJ)*

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria;
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** and **coinsurance** as your cost sharing is based on the type of service provided.

Orthotic or Prosthetic Appliances Expense

Covered expenses include charges made for orthotic or prosthetic appliances from a licensed orthotist or prosthetist or any certified pedorthist, if determined medically necessary by the covered person's physician.

Reimbursement for orthotic and prosthetic appliances is made to the Provider at the same rate as such appliances under the federal Medicare reimbursement schedule. If the contracted rate is higher than the rate under the Federal Medicare reimbursement schedule, the recognized charged will be reimbursed.

The Covered Percentage and **Copayment** are shown on the Schedule of Benefits.

For the purposes of this section:

"Orthotic Appliance" means a brace or support but does not include fabric and elastic and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

"Prosthetic Appliance" means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as *artificial breast, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

*For covered expenses for a prosthetic device following a mastectomy, refer to the *Reconstructive Breast Surgery and Mastectomy* section of this Certificate.

Short-Term Rehabilitation Therapy Services *(GR-9N-11-120-01)*

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Therapy.

- Cardiac therapy benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Pulmonary therapy benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

A "visit" consists of no more than 1 hour of therapy. Covered expenses include charges for 2 therapy visits of no more than 1 hour in a 24-hour period.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Outpatient Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient **hospital** and **skilled nursing facility** benefits provision in this Booklet-Certificate.

- Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth, except as **medically necessary** for your treatment of a **Mental Disorders**. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Speech therapy is also covered for treatment of Autism and Other Developmental Disabilities.
- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, except as **medically necessary** for your treatment of a **Mental Disorders**. Physical therapy does not include educational training or services designed to develop physical function, except as required to treat Autism or Other Developmental Disabilities.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to re-learn skills to significantly improve independence in the activities of daily living, except as **medically necessary** for your treatment of a **Mental Disorders**. Occupational therapy does not include educational training or services designed to develop physical function, except as required to treat Autism or Other Developmental Disabilities.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums. Please note that the applicable benefit maximums may apply to each type of short-term rehabilitation therapy services, or may be a combined benefit maximum for all or certain types of short-term rehabilitation therapy services. This maximum will not apply to **Mental Disorders** which will be paid subject to the same terms and conditions as any other illness. The limitations on therapy services do not apply to the Diagnosis and Treatment of Autism or Other Developmental Disabilities.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism and Other Developmental Disabilities. Physical therapy, occupational therapy and speech therapy services for the treatment of Autism and Other Developmental Disabilities are subject to both the maximums shown in the *Schedule of Benefits* applicable to this coverage and to the maximum benefits for Autism and Other Developmental Disabilities, if any.
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from **illness**, **injury**, or congenital defect.
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;

- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies for:

- Surgery to correct the result of an accidental **injury** provided the surgery occurs no more than 24 months after the injury. For a covered child, surgery will be covered up to age 18 or up to 24 months after the **injury**, whichever period is longer. Injuries that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct medically diagnosed congenital defects and birth abnormalities. The surgery will be covered if the defect results in severe facial disfigurement or significant functional impairment of a body part; and the purpose of the surgery is to improve function.
- Other surgery needed when the treatment of an **illness** results in severe facial disfigurement or significant functional impairment of a body part. The surgery must be needed to improve function.

Coverage is provided under the same terms and conditions as for any other **illness** or **injury**. Please refer to the *Schedule of Benefits* for any applicable **deductible** and **coinsurance** as your cost sharing is based on the type of service provided.

Reconstructive Breast Surgery and Mastectomy

Covered expenses and expenses include charges following a mastectomy on one breast or both breasts, for reconstructive breast surgery:

- Surgery to restore and achieve symmetry between two breasts;
- Costs of prostheses;
- Outpatient x-ray or radiation therapy; and
- Costs of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer shall be included as a part of the outpatient chemotherapy x-ray or radiation therapy coverage.

The following coverage is provided for a person following a mastectomy under inpatient **hospital** coverage:

- A minimum of 72 hours of inpatient care following a modified radical mastectomy;
- A minimum of 48 hours inpatient care following a simple mastectomy; or
- A shorter length of stay, if the patient, in consultation with the patient's **physician**, determines that a shorter length of stay is medically appropriate.

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** and **coinsurance** as your cost sharing is based on the type of service provided.

Specialized Care *(GR-9N 11-135-01)*

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Radiation Therapy

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Infusion Therapy

Covered expenses include charges made on an outpatient basis for **infusion therapy** by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are **medically necessary** for your course of treatment. Charges for the following outpatient **infusion therapy** services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with **infusion therapy** and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives); and
- Blood infusion and transfusions and blood products.

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Dialysis; and
- Insulin.

Coverage is subject to the applicable **deductible** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for **infusion therapy** will not count toward any applicable **Home Health Care** maximums shown in the *Schedule of Benefits*.

If **infusion therapy** is provided as part of a **home health care program** it will be subject to the applicable Home Health Care maximum.

Your cost sharing may be different depending if services are performed at a **hospital** outpatient facility or performed at a facility other than a **hospital** outpatient facility. Please refer to the *Schedule of Benefits* for the appropriate cost sharing.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy when ordered or prescribed by a **physician** (or nurse practitioner or clinical nurse specialist):

- External insulin pumps and appurtenances;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Coverage also includes diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Such coverage for self-management education and education relating to diet shall be limited to visits **medically necessary** upon the diagnosis of diabetes, where a **physician** (or nurse practitioner or clinical nurse specialist) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a person's self-management, or where re-education or refresher education is necessary. Such education must be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health professional recognized as a Certified Diabetes Educators by the American Association of Diabetes Educators, or a registered pharmacist qualified with regard to management education for diabetes by any institution recognized by a state board of pharmacy.

Coverage is provided under the same terms and conditions as any other illness under this Booklet-Certificate.

Inherited Metabolic Diseases (GR-9N 11-135-01)

Coverage is provided for expenses incurred in the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be medically necessary by your physician.

Inherited metabolic disease is a disease by an inherited abnormality of body chemistry for which testing is mandated by law.

Low protein modified food product are food products that are specially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include natural food that is naturally low in protein.

Medical foods are foods that are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered internally under the direction of a physician.

Coverage is provided under the same terms and conditions as for any other illness. Please refer to the Schedule of Benefits for any applicable deductible or coinsurance as your cost sharing is based on the type of service provided. For any service not otherwise specifically listed on the Schedule of Benefits, refer to "Other Covered Expenses" on the Schedule of Benefits for applicable cost sharing.

Treatment for Infertility *(GR-9N 11-135-01)*

Infertility is a **disease** or condition that results in the abnormal function of the reproductive system such that:

- You are not able to impregnate another person;
- You are not able to conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older;

- One of the partners is determined to be medically sterile; or
- You are not able to carry a pregnancy to live birth.

Coverage is provided under the Plan for **medically necessary** expenses incurred in the diagnosis and treatment of **infertility**. Covered **infertility** services include, and are not limited to:

- Diagnosis and diagnostic tests;
- **Prescription drugs**;
- Surgery;
- Artificial insemination;
- Fresh and cryopreserved embryo transfer (e.g., transfers of thawed, previously frozen embryos);
- In-vitro fertilization (IVF), gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT);
- Ovulation induction;
- Intractoplasmic sperm injection (ICSI);
- Assisted hatching;
- Microsurgical Sperm aspiration;
- Care of a covered female who is participating in a donor IVF program, including fertilization and culture; the transfer of the embryo, and synchronization of the covered person's cycle with the donor's cycle;
- The medical costs of the donor, where a live donor is used, until the donor is released from treatment by the reproductive endocrinologist;
- Obtaining the sperm of a covered female's partner; and
- Not more than a total of four complete egg retrievals will be covered during a female lifetime. Egg retrievals where the cost is not covered by any plan or program will not count in determining this limitation. Egg retrieval is a procedure to collect eggs contained in the ovarian follicles.

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible**, **coinsurance**, **copayment** as your cost sharing is based on the type of service provided. For any service not otherwise specifically listed on the *Schedule of Benefits*, refer to "Other Covered Expenses" on the *Schedule of Benefits* for applicable cost sharing.

The following **infertility** services and supplies are hereby excluded from coverage:

- Charges associated with cryopreservation, storage of cryopreserved sperm, eggs or embryos;
- **Infertility** treatments that are **experimental or investigational** in nature;
- Home ovulation predictor kits, sperm testing kits and supplies;
- **Prescription drugs** related to the treatment of non-covered benefits or related to the treatment of **infertility** that are not **medically necessary**;
- Non-medical costs of an egg or sperm donor;
- Reversal of prior voluntary sterilization procedures;
- Any charges associated with obtaining sperm for non-covered persons;
- Gestational carrier expenses, except for embryo transfers;
- Services rendered to a surrogate for the purposes of childbearing, if the surrogate in not a covered person; and
- **Infertility prescription drugs** to the extent covered elsewhere under this Booklet-Certificate or under another Group Plan sponsored by the policyholder.

Limitations
Infertility procedures involving IVF, GIFT, and ZIFT are subject to the following limitations:

- These procedures are covered only if a successful pregnancy cannot be attained through less expensive and medically appropriate treatments available under this policy;
- Not more than a total of four complete egg retrievals will be covered during a female lifetime. Egg retrievals where the cost is not covered by any plan or program will not count in determining this limitation. Egg retrieval is a procedure to collect eggs contained in the ovarian follicles.

Spinal Manipulation Treatment *(GR-9N 11-155-01)*

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Coverage is subject to the applicable **deductible**, **copayment** and **coinsurance** shown in the *Schedule of Benefits*.

Please refer to the *Schedule of Benefits* for any applicable benefit maximums. Please note that the applicable benefit maximums may apply individually to spinal manipulation treatment or may be combined with the benefit for certain types of short-term rehabilitation therapy services.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury, covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Cleft Lip or Palate Treatment

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment. Refer to the Short-Term Rehabilitation Therapy Services section for covered therapy services.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** and **coinsurance** as your cost sharing is based on the type of service provided. For any service not otherwise specifically listed on the *Schedule of Benefits*, refer to "Other Covered Expenses" on the *Schedule of Benefits* for applicable cost sharing.

Transplant Services *(GR-9N-S-11-160-01 NJ)*

Covered expenses include charges incurred during a Transplant Occurrence. Once it has been determined that you or one of your dependents may require an organ transplant, you or your physician should call **Aetna** to obtain the necessary precertification. Organ means solid organ; stem cell; bone marrow; and tissue.

For purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;

- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under this Plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The Plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Please refer to the *Schedule of Benefits* for any applicable transplant benefit maximums.

Autologous bone marrow transplant for Wilm's tumor
Coverage is provided when standard chemotherapy treatment is unsuccessful and autologous bone marrow transplant and peripheral blood stem cell transplant, notwithstanding that any such treatment may be deemed **experimental or investigational**.

Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** and **coinsurance** as your cost sharing is based on the type of service provided.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Limitations
Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Treatment of Mental Disorders and Substance Abuse *(GR-9N 11-172 01 NJ)*
Covered expenses include charges made for the treatment of **mental disorders** and **substance abuse** by **behavioral health providers**.

Important Note
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

Mental Disorders
Covered expenses include charges made for the treatment of **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- This Plan includes follow-up treatment; and
- This Plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**.

Important Reminder
Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

This plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Please refer to the *Schedule of Benefits* for any **mental disorders** and **substance abuse deductibles**, maximums and maximum out of pocket that may apply to your **mental disorders** and **substance abuse** benefits.

Important Reminders
- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums and maximum out of pocket that may apply to your **mental disorders** and **substance abuse** benefits.

Substance Abuse

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers.** In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of **substance abuse**.

Please refer to the *Schedule of Benefits* for any **mental disorders** and **substance abuse deductibles**, maximums and maximum out of pocket that may apply to your **mental disorders** and **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder
Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Important Reminder
Inpatient treatment, partial-**hospitalization** care and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums and maximum out of pockets that may apply to your **mental disorders** and **substance abuse** benefits.

Family Planning Services *(GR-9N S-11-191-01)*

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an **illness** or **injury**.

Contraception Services

Covered expenses include charges provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Consultations;
- Exams;
- Procedures; and
- Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning
Covered expenses include the following charges for family planning services:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Also see the *Maternity Expenses* section and the *Treatment of Infertility* section for related expenses.
Coverage is provided under the same terms and conditions as for any other **illness**. Please refer to the *Schedule of Benefits* for any applicable **deductible** or **coinsurance** as your cost sharing is based on the type of service provided.

Behavioral Health Services:

- Drug abuse rehabilitation treatment and **detoxification** on an inpatient or outpatient basis;
- Non biologically-based mental health services, inpatient and outpatient;
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
- Treatment in wilderness programs or other similar programs.

Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to treatment of **Mental Disorder** or to medical treatment of mentally retarded covered persons in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge,** or an **out-of-network provider** in excess of the **recognized charge**.

Charges which are submitted for services or supplies that are not rendered.

Charge which are submitted for a person who is not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery (except coverage will be provided for covered newborns from the moment of birth for the **medically necessary** care and treatment of medically diagnosed congenital defects and birth abnormalities): any treatment, surgery (cosmetic or plastic), service or supply to alter the shape or appearance of the body except as specifically described under *Reconstructive Services* and *Specialized Care* sections of the *What the Plan Covers* section including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;

- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

Costs for services resulting from the commission or attempt to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation.

Services and treatment for marriage counseling, religious counseling, family counseling, career counseling, social adjustment counseling, pastoral counseling, or financial counseling.

Court ordered services, including those required as a condition of parole or release.

Custodial care

Dental Services: Except as specifically described in the *What the Plan Covers* Section, any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient; except for those supplies otherwise covered for diabetes.

Drugs, medications and supplies (except oral agents for diabetes and **infertility** medications):

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel or work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Implantable drugs and associated devices;

Educational services:

Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training

related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This item does not apply to the treatment of **Mental Disorders**, including pervasive developmental disorders, developmental disabilities and autism as provided in the **Covered Benefits** section.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

  Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individuals primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

The food item exclusion will not apply to the dietary treatment of a disease or condition based on an Inherited metabolic disease.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (except orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing, including aids hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech except as covered under the dependent hearing aid provision.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:

- Bathroom equipment such as bathtub seats, benches, rails, and lifts;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Home uterine activity monitoring.

Maintenance Care.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as provided under a **home health care plan**.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse/civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered preventive care which includes, but not limited to routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without a **referral** issued by the **PCP** when required or **precertification** by **Aetna** when required. **Aetna** will reduce benefits by 50% with respect to charges for treatment, services and supplies which have not been Precertified by **Aetna** provided that benefits would otherwise be payable under this Booklet-Certificate. This exclusion does not apply to treatment of an **emergency medical condition** or **urgent care** condition.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Anti-reflective coatings;
- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;

- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet-Certificate, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements(will not apply for the dietary treatment of a disease or condition based on Inherited metabolic disease), appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment including any **injuries** that arise out of (or in the course of) any work for pay or profit and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law. Reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause. This exclusion does not apply to the following individuals for whom coverage under workers' compensation is optional, unless such individuals are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actually perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Your Pharmacy Benefit *(GR-9N-12-005-02)*

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents. You can refer to *Eligibility* for a complete definition of "you."
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet-Certificate as covered expenses that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be **covered expenses** under this **prescription drug** plan.
- Store this Booklet-Certificate in a safe place for future reference.

Notice
The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet-Certificate.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.

Getting Started: Common Terms *(GR-9N-12-010-02 NJ)*

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this Booklet-Certificate for helpful definitions. Words in bold print throughout the Booklet-Certificate are defined in the *Glossary*.

Brand-Name Prescription Drug is a **prescription drug** as determined by the Food and Drug Administration (FDA) and is protected by the trademark registration of the pharmaceutical company which produces them.

Generic Prescription Drug is a therapeutically equivalent **prescription drug**, as determined by the Food and Drug Administration (FDA), and which is identical to the **brand-name prescription drug** in strength or concentration, dosage form and route of administration.

Network pharmacy is a description of a **retail** or **mail order pharmacy** that has entered into a contractual agreement with **Aetna, an affiliate, or a third party vendor** for the provision of **covered services** to you and your covered dependents at a . The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (e.g. **network retail pharmacy** or **network mail order pharmacy** or **specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-name prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna, an affiliate, or a third party vendor** and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-name prescription drug** or **generic prescription drug** that appears on the **preferred drug list (Formulary).**.

Preferred Drug List (Formulary) is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna**. A copy of the **preferred drug list** is available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin and those medically necessary for the treatment of infertility.

Provider is any recognized health care professional, **pharmacy** or facility providing services with the scope of their license.

Self-injectable Drug(s) are **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Specialty Care Drugs

Prescription drugs include injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the specialty care drug list.

Accessing Pharmacies and Benefits *(GR-9N-12-015-02 NJ)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your **prescriptions** and supplies through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network coverage**. Cost sharing may also vary whether or not you purchase a **brand-name** or **generic drug**. **Network pharmacies** include retail and mail order and specialty pharmacy network.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

To better understand the choices that you have with your plan, please carefully review the following information.

Accessing Network Pharmacies and Benefits *(GR-9N-12-015-02)*

You may select a **network pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area call Member Services.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network **benefits**. The **network pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions *(GR-9N-12-015-02 NJ)*

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any **network retail pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less any applicable cost sharing required by you.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Expense Provisions and the Schedule of Benefits.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy *(GR-9N-12-020-01 NJ) (GR-9N-S-13-005-01 NJ)*

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits *(GR-9N-12-020-01 NJ)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Expense Provisions and the Schedule of Benefits.

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit *(GR-9N-S-13-005-01 NJ)*

What the Plan Covers

The plan covers charges for outpatient **prescription drugs** and female **prescription** contraceptives for the treatment of an **illness** or injury, subject to the Limitations section of this coverage and the Exclusions section of the Booklet-Certificate. Prescriptions must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Coverage of **prescription drugs** may be subject to **precertification**, or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or **your network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **retail pharmacy**. **Prescriptions** for more than a 90 day supply are not eligible for coverage when dispensed by a **retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **mail order pharmacy**. **Prescriptions** for more than a 90 day supply are not eligible for coverage when dispensed by a **mail order pharmacy**.

Specialty Care Drug Benefit

Network Benefits for Specialty Care Drugs.

Specialty care drugs are covered at the network level of benefits only when dispensed through a **network** retail **pharmacy** or **Aetna's specialty pharmacy network**. Refer to **Aetna's** website, www.aetna.com to review the list of **specialty care drugs** required to be dispensed through a **network** retail **pharmacy** or **Aetna's specialty pharmacy network**. The list may be updated from time to time.

Out-of-Network Benefits for Specialty Care Drugs.

Specialty care drugs are covered at the **out-of-network level** of benefits when obtained from an **out-of-network pharmacy**.

Other Covered Expenses *(GR-9N-S-13-005-01 NJ)*

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use *(GR-9N-S-13-005-01 NJ)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information) or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. When covered, **prescription drugs** approved for off-label use are subject to the same terms, conditions, limitations, and exclusions as other **prescription drugs** covered under the plan.

Diabetic Supplies *(GR-9N-S-13-005-01 NJ)*

The following diabetic supplies upon prescription by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading and urine testing strips.
- Blood Glucose Monitors.
- Lancets/lancing devices.
- Alcohol swabs.
- Cartridges for the legally blind.
- Insulin pumps and appurtenances.
- Insulin infusion services.

Prescription Female Contraceptives
This means any drug or device used for contraception by a female, which is approved by the Federal Food and Drug Administration for that purpose, that can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions and includes, but is not limited to, birth control pills and diaphragms.

Infertility Prescription Drugs

Infertility prescription drugs including injectable **infertility prescription drugs**, used for the purpose of treating **infertility** are covered, if **medically necessary**. **Infertility prescription drugs** will be provided under the same terms and conditions as provided for any other prescription under this Prescription Plan.

Lifestyle/Performance Drugs
The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order supplies are not covered.

Benefits for Non-Standard Infant Formulas

Certain infant formulas are covered when:

- The covered dependent's infant (birth through 12 months) has been diagnosed as having multiple food protein intolerance and a **physician** has determined that specialized, non-standard, formulas are **medically necessary**; and
- The covered dependent's infant (birth through 12 months) has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Precertification *(GR-9N-S-13-010-01-NJ)*
Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** or an affiliate to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and modification by **Aetna**. An updated copy of the list of drugs requiring **precertification** shall be available upon request or may be accessed on line and can be found in the **Aetna preferred drug guide** available online at www.aetna.com/formulary.

Failure to request **precertification** will result in reduction of benefits (see your *Schedule of Benefits*), or denial of coverage, so be sure to ask your **prescriber** or pharmacist if the drug being considered requires **precertification.**

How to Obtain Precertification *(GR-9N-S-13-010-01-NJ)*
If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified**.

If **precertification** is denied **Aetna** will notify you how the decision can be appealed.

Medical Exceptions Process

A covered Non-Formulary **Prescription Drug** will be considered at the **Formulary** benefit level if:

- Its use is supported by one or more citations included in, or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia Drug Information; or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and
- The prescribing provider documents that all **prescription drugs** on the drug **Formulary** have been ineffective in the treatment of your disease or condition, or all **prescription drugs** on the drug **Formulary** cause, or are reasonably expected to cause, adverse or harmful reactions in you.

Aetna will respond to the provider by telephone or other telecommunications device within 24 hours of a request for **precertification**. Failure of **Aetna** to respond within 24 hours may be deemed an approval of the request.

Clinical denials shall be issued to you and the provider in writing within 5 days of receipt of the request for approval of coverage of a **non-formulary prescription drug**. The denial shall include the clinical reason for the denial and that denial can be appealed to the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to P.L. 1997, c. 192, section 11. Refer to the *Complaint and Appeals* section in your Booklet-Certificate for details of the appeal process.

Pharmacy Benefit Limitations *(GR-9N-S-13-015-01 NJ)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Pharmacy Benefit Exclusions *(GR-9N-28-020-01 NJ)*

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

- Administration or injection of any drug.
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet-Certificate.
- Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved; except as provided for under the medical and **prescription** coverage sections of this Booklet-Certificate. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera.

(GR-9N-28-020-01 NJ)
Contraception:

- over the counter contraceptive supplies including but not limited to: condoms, contraceptive foams, jellies and ointments; and
- Services associated with the monitoring and/or administration of contraceptives.

Contraception, except for female contraceptive **prescription drugs** that are prescribed for reasons other than contraceptive purposes to treat an **illness** or **injury** and prescription female contraceptives that are necessary to preserve the life or health of the covered person.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin (except coverage will be provided for covered newborns from the moment of birth for the **medically necessary prescription drugs** used for the treatment of medically diagnosed congenital defects and birth abnormalities).

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

(GR-9N-28-020-01 NJ)
Drugs or supplies for the treatment of any **illness** or **injury** related to employment including any **injuries** that arise out of (or in the course of) any work for pay or profit and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law. Reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause. This exclusion does not apply to the following individuals for whom coverage under workers' compensation is optional, unless such individuals are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actually perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements (except for food and food supplements for the dietary treatment of a disease or condition based on an inherited metabolic disease), food or food supplements, appetite suppressants and other medications.

Drugs used for the treatment of obesity.

(GR-9N-28-020-01 NJ)
Durable medical and surgical equipment, monitors and other equipment.

For drugs, except insulin, which can be obtained legally without a **prescription** order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter (OTC) product (i.e., same strength and active ingredient) is available even when a **prescription** is written.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including infant formulas, (not including specialized non-standard infant formula), nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion will not apply for food and food supplements for the dietary treatment of a disease or condition based on an inherited metabolic disease.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, injectables or supplies given through a third party vendor contract with the policyholder.

(GR-9N-28-020-01 NJ)
Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Prophylactic drugs for travel.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N-30-005-05 NJ)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops for any reason, including a job elimination or being placed on severance, except as described in the *Extension of Benefits* and *A Totally Disabled Employee's Right to Continue Health Benefits* section of the Booklet-Certificate. This will be either the end of the month, end of the month following the month in which you stop active work, or the day before the first premium due date that occurs after you stop active work, whichever occurs first. The premium due date is the 30th day of the calendar month. The policyholder or the policyholder's authorized representative must remit premiums for your continued coverage to **Aetna** by the end of the grace period. However, if you make premium payments or premium payments are made on your behalf, **Aetna** will consider your employment to continue, for purposes of remaining eligible for coverage under this Plan. as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 30 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day your are actively at work before the start of the lay-off or leave of absence.

If you are totally disabled you shall be entitled to continue your health insurance in accordance with the *Extension of Benefits* and *A Totally Disabled Employee's Right To Continue Health Benefits* sections.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage *(GR-9N-30-010-03 NJ)*

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents *(GR-9N-30-015-03 NJ)*

Coverage for your dependents will end if:

- The date you are no longer eligible for dependents' coverage;
- The date you do not make the required contribution toward the cost of dependents' coverage;
- The date your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (other than exhaustion of your overall maximum lifetime benefit, if included);
- When your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N-31-010-05 NJ)*

Continuing Health Care Benefits *(GR-9N-31-015-06)*

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS

(GR-9N-31-015-06 NJ) (Applies to all size groups):

As used in this provision, "Over-Age Dependent" means your child by blood or law who:

a) has reached the limiting age as described in the Dependent Eligibility section of this Certificate, but is less than 31years of age;
b) is not married or in a domestic partnership or civil union partnership;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage

If a Dependent Child is over the limiting age for dependent coverage and:

a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of the limiting age; or
b the Dependent child has proof of prior creditable coverage or receipt of benefits, he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends section below.

Conditions for Election

An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met:

a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been effect at some time prior to making an election for this Over-Age Dependent coverage,
b) A parent of an Over-Age Dependent must be enrolled as having elected dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a e Spouse/**domestic or civil union partner** who is covered elsewhere, the Over-Age Dependent may nonetheless select continued coverage.

Election of Continuation
To continue group health benefits, the Over-Age Dependent must make written election to **Aetna**. The effective date of the continued coverage will be the later of:

a) the date the Over-Age Dependent gives written notice to **Aetna**; or
b) the date the Over-Age Dependent pays the first premium; or
c) the date the dependent would otherwise lose coverage due to attainment of the limiting age.

For a dependent whose coverage has not yet terminated due to the attainment of age of the limiting age, as applicable, the written election must be made within 30 days prior to termination of coverage, due to the attainment of age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result is a lapse of coverage. See the Application of a Pre-Existing Conditions Exclusion section below.

For a person who did not qualify as an Over-Age Dependent because he or she fails to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-Existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy. The Pre-Existing Conditions Exclusion will not apply to a dependent under 19 years of age.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, at the times and in the manner specified by **Aetna**. The monthly premium will be set by **Aetna**, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an employee under the Policy. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
An **Over-Age Dependent**'s continued group health benefits end on the first of the following:

a) the date the **Over-Age Dependent**:
   1. attains the age 31;
   2. marries or enters into a domestic or civil union partnership;
   3. acquires a dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.
b) the end of the period for which premium has been paid for the **Over-Age Dependent**, subject to the grace period for such payment;

c) the date the Policy ceases to provide coverage to the **Over-Age Dependent**'s parent who is the employee under the Policy;
d) The date the Policy under which the **Over-Age Dependent** elected to continue coverage is amended to delete coverage for dependents.

The date the **Over-Age Dependent**'s parent who is covered as an employee under the Policy waives dependent coverage. Except, if the employee has no other dependents, the **Over-Age Dependent**'s coverage will not end as a result of the employee waiving dependent coverage.

Continuing Coverage for Dependent Students on Medical Leave of Absence *(GR-9N-31-015-05 NJ)*

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children *(GR-9N-31-015-05 NJ)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of an intellectual disability or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of dependent coverage as to your child, as stated in the "When Coverage Ends for Dependents" section, other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Extension of Benefits *(GR-9N-31-020-03 NJ)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled due to discontinuance of the health policy, your health expenses incurred in connection with the **injury** or **illness** that caused the total disability, will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit for which you are reasonably fitted by education, training and experience.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage *(GR-9N-31-020-03 NJ)*

(GR-9N-31-020-03 NJ)
Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE HEALTH BENEFITS *(GR-9N-31-020-03 NJ)*

If an Employee is Totally Disabled
An employee who is totally disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been covered by the Plan for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the employee, and at his or her option, his or her then covered dependents.

How and When to Continue Coverage
To continue group health benefits, the employee must give the employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under the Plan would otherwise end.

Subsequent premiums must be paid to the employer monthly, in advance, at the times and in the manner specified by the employer. The monthly premium the employee must pay will be the total rate charged for an active full-time or part-time employee, covered under the Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the employer.

Aetna will consider the employee's failure to give notice or to pay any required premium as a waiver of the employee's continuation rights.

If the Employer fails, after the timely receipt of the employee's payment, to pay **Aetna** on behalf of such employee, thereby causing the employee's coverage to end; then such employer will be liable for the employee's benefits, to the same extent as, and in place of, **Aetna**.

When This Continuation Ends
These continued group health benefits end on the first of the following:

a) the end of the period for which the last payment is made, if the employee stops paying;
b) the date the covered person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date the Plan ends or is amended to end for the class of employees to which the employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible dependent as defined in the Plan.

For purposes of this provision, "totally disabled or total disability" means, an employee who, due to **illness** or **injury**, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. The employee must be under the regular care of a health care provider.

COBRA Continuation of Coverage *(GR-9N-31-025-02 NJ)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

You and your covered dependents may be eligible to continue group health benefits under the COBRA Continuation of Coverage section and under other continuation sections of the plan at the same time. If an individual is eligible to continue group health benefits under both the plan's COBRA Continuation of Coverage section and certain other continuation provisions of the plan, your rights to elect continuation and the benefits provided may be affected.

Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify the individual for continuation under this section, is covered for group health benefits under the Contract as:

- an active, covered employee;
- the spouse of an active, covered employee; or
- the dependent child of an active, covered employee. Except as stated below, any person who becomes covered under the plan during a continuation provided by this section is not a Qualified Continuee.

Exceptions:

- A child who is born to the covered employee, or who is placed for adoption with the covered employee during the continuation provided by this section is a Qualified Continuee.
- If you are a civil union partner, who is eligible for COBRA continuation of coverage you may elect COBRA continuation of coverage for you and your eligible dependents, including a civil union partner. However, an eligible dependent who is a **civil union partner**, may not make a COBRA continuation of coverage election for themselves and their eligible dependents after any event that would otherwise give rise to COBRA rights, as they do not meet the federal definition of a "qualified beneficiary" under COBRA rules.

If An Employee's Group Health Benefits Ends
If your group health benefits end due to termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, unless you were terminated due to gross misconduct.

A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:

- is covered under another group plan on or before the date of the COBRA election; or
- is entitled to Medicare on or before the date of the COBRA election.

The continuation:

1. may cover you and any other Qualified Continuee; and
2. is subject to the When Continuation Ends section.

Additional Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date their group health benefits would otherwise end due to the employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, the individual and any Qualified Continuee who is not disabled may elect to extend their 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the employer written proof of Social Security's determination of his or her disability before the earlier of:

- the end of the 18 month continuation period; and
- 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, the individual must notify the employer within 30 days of such determination, and continuation will end, as outlined in the When Continuation Ends section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the employer during this extra 11 month continuation period.

If An Employee Dies While Covered
If an employee dies while covered, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage Ends
If an Employee's marriage ends due to legal divorce or legal separation, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the plan, other than the employee's coverage ending, they may elect to continue such benefits. However, such dependent child must be a Qualified Continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

Concurrent Continuations
If a dependent elects to continue group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

- the dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
- the employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the "special rule" applies to dependents of an employee when the employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a dependent upon the employee's subsequent termination of employment or reduction in work hours will be the longer of the following:

- 18 months from the date of the employee's termination of employment or reduction in work hours; or
- 36 months from the date of the employee's earlier entitlement to Medicare.

Exception: If the employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this "special rule" will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the employer, in writing, of:

- the legal divorce or legal separation of the Employee from his or her spouse; or
- the loss of dependent eligibility, as defined in the plan, of a covered dependent child.

Such notice must be given to the employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:

- his or her right to continue the plan's group health benefits;
- the monthly premium the individual must pay to continue such benefits; and
- the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:

- the date a Qualified Continuee's group health benefits would otherwise end due to the employee's death or the employee's termination of employment or reduction of work hours; or
- the date a Qualified Continuee notifies the employer, in writing, of the employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered dependent child.

The Employer's Liability
The employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, **Aetna**, if:

- the employer fails to remit a Qualified Continuee's timely premium payment to **Aetna** on time, thereby causing the Qualified Continuee's continued group health benefits to end;
- the employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue health benefits, the Qualified Continuee must give the employer written notice that they elect to continue coverage. An election by a minor dependent child can be made by the dependent child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed covered under the plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the employer.

If the Qualified Continuee fails to give the employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer or **Aetna**.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

- with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:
  - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
  - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- with respect to continuation upon the Employee's death, the employee's legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- with respect to a dependent whose continuation is extended due to the employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- the date the plan ends;
- the end of the period for which the last premium payment is made;
- the date the individual becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of Creditable Coverage;
- the date the individual becomes entitled to Medicare;
- termination of a Qualified Continuee for cause on the same basis that the employer terminates coverage of an active employee for cause.

Conversion from a Group to an Individual Plan
You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment;
- When loss of coverage under the group plan occurs;
- When loss of dependent status occurs;
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

Converting to an Individual Medical Insurance Policy *(GR-9N-31-040-01 NJ)*

Eligibility
You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage and generally the coverage level will be less.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits).

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna**'s normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means the charge for any health care service, supply or other item of expense for which the person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When **This Plan** is coordinating benefits with a Plan that provides benefits only for dental care, vision care, **prescription drugs** or hearing aids, **Allowable Expense** is limited to like items of expense.

Aetna will not consider the difference between the cost of a private **Hospital** room and that of a semi-private **Hospital** room as an **Allowable Expense** unless the **stay** in a private room is **Medically Necessary**.

When **This Plan** is coordinating benefits with a **Plan** that restricts **COB** to a specific coverage, **This Plan** will only consider corresponding services, supplies or items of expense to which **COB** applies as an **Allowable Expense**.

"Claim Determination Period" means a calendar year or portion of a calendar year, during which a person is covered by **This Plan** and at least one other **Plan** and incurs one or more **Allowable Expense**(s) under such **Plans**.

"**Coordination of Benefits (COB)"** means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more **Plans**. It avoids claims payment delays by establishing an order in which **Plans** pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a **Plan** when, by the rules established by this provision, it does not have to pay its benefits first.

"**Plan**(s)" means coverage with which **COB** is allowed. **Plan** includes:

i. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
ii. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
iii. Group or group-type coverage through a Health Maintenance Organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
iv. Group **hospital** indemnity benefit amounts that exceed $150 per day;
v. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

"**Plan**(s)" shall not include:

i. Individual or family insurance contracts or subscriber contracts;
ii. Individual or family coverage through an HMO or under any other prepayment, group practice and individual practice plans;
iii. Group or group-type coverage where the cost of the coverage is paid solely by the Member except when coverage is being continued pursuant to Federal or State continuation law;
iv. Group **hospital** indemnity benefit amounts of $150.00 per day or less;
v. School accident-type coverage;
vi. A State plan under Medicaid.

"This Plan" is the part of this Certificate that provides benefits for health care expenses.

"**Primary Plan**(s)" means a **Plan** whose benefits for a person's heath care coverage must be determined without taking into consideration the existence of any other **Plan**. There may be more than one **Primary Plan**. A **Plan** will be the **Primary Plan** if:

i. the **Plan** has no order of benefit determination rules, or it has rules that differ from those contained in this Certificate; or
ii. all **Plans** which cover the person use order of benefit determination rules consistent with those contained in this Certificate and under those rules, the Plan determines its benefit first.

"**Reasonable Charge**" means an amount this is not more than the usual or customary charge for the service or supply as determined by **This Plan**, based on a standard which is most often charged for a given service by a provider within the same geographic area.

"**Secondary Plan(s)**" means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this COB section shall be used to determine the order in which the benefits payable under the multiple **Secondary Plans** are paid in relation to each other. The benefits of each **Secondary Plan** may take into consideration the benefits of the **Primary Plan** or **Plans** and the benefits of any other **Plan** which, under this Certificate, has its benefits determined before those of that **Secondary Plan**.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered one **plan**.

Primary and Secondary Plan:
This **Plan** considers each **Plan** separately when coordinating payments.

The **Primary Plan** pays or provides services or supplies first, without taking into consideration the existence of a **Secondary Plan**. If a **Plan** has no **COB** provision, or if the order of benefit determination rules differ from those set forth in this **Certificate**, it is the **Primary Plan**.

Secondary Plan takes into consideration the benefits provided by a **Primary Plan** when, according to the rules set forth below, the **Plan** is the **Secondary Plan**. If there is more than one **Secondary Plan**, the order of benefit determination rules determines the order among the **Secondary Plans**. The **Secondary Plans** will pay up to the remaining unpaid **Allowable Expenses**, but no **Secondary Plan** will pay more than it would have paid if it had been the **Primary Plan**. The method the **Secondary Plan** uses to determine the amount to pay is set forth below in the "Procedures to be followed by the **Secondary Plan** to Calculate Benefits" section.

Which Plan Pays First

Rules for the Order of Benefit Determination:
The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree shall be determined before those of the **Plan** that covers the person as a dependent. The coverage as an employee, member, subscriber or retiree is the **Primary Plan**.

The benefits of the **Plan** that covers the person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the **Plan** that covers the person as a laid off or retired employee, or as such a person's dependent. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

The benefits of the **Plan** that covers the person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the **Plan** that covers the person under a right of continuation pursuant to Federal or State law. If the other **Plan** does not contain this rule, and as a result the **Plans** do not agree on the order of benefit determination, this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are neither separated nor divorced, the following rules apply:

i. The benefits of the **Plan** of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
ii. If both parents have the same birthday, the benefits of the **Plan** which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
iii. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
iv. If the other **Plan** contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a dependent under **Plans** through both parents, and the parents are separated or divorced, the following rules apply:

i. The benefits of the Plan of the parent with custody of the child shall be determined first.
ii. The benefits of the Plan of the spouse/**civil union partner** of the parent with custody shall be determined second.

iii. The benefits of the Plan of the parent without custody shall be determined last.
iv. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that **Plan** has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the **Plan** of the other parent shall be considered as secondary. Until the entity providing coverage under the **Plan** has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which **Plan** is the **Primary Plan**, the benefits of the **Plan** that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the **Plans** that covered the person for a shorter period of time.

How Coordination of Benefits Works

Procedures to be followed by the Secondary Plan to Calculate Benefits
In order to determine which procedure to follow it is necessary to consider:

i. the basis on which the **Primary Plan** and the **Secondary Plan** pay benefits; and
ii. whether the provider who provides or arranges the services and supplies is in the network of either the **Primary Plan** or the **Secondary Plan**.

Benefits may be based on the **Reasonable Charge**, or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the bill charge. In this section, "**Reasonable Charge Plan**" means a plan that bases benefits on a Reasonable Charge.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a "**Network Provider**", bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, "Fee Schedule Plan(s)" means a **Plan** that bases benefits on a negotiated fee schedule. If the covered person uses the services of a **non-network provider**, the **Plan** will be treated as a **Reasonable Charge Plan** even though the **Plan** under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means an HMO or other plan pays the **Network Provider** a fixed amount per covered person. The covered person is liable only for the applicable **deductible**, **coinsurance** or **copayment**. If the covered person uses the services of a **non-network provider**, an HMO or other plan will only pay benefits in the event of emergency care or **urgent care**. In this section, "Capitation Plan" means a **Plan** that pays **Network Providers** based upon capitation.

<u>Primary and Secondary Plans are Fee Schedule Plans</u>
If the provider is a **Network Provider** in both the **Primary Plan** and the **Secondary Plan**, the **Allowable Expense** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The total amount the provider receives from the **Primary Plan**, the **Secondary Plan** and the covered person shall not exceed the fee schedule of the **Primary Plan**. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

<u>Primary Plan is Reasonable Charge Plan and Secondary Plan is Fee Schedule Plan</u>
If the provider is a **Network Provider** in the **Secondary Plan**, the **Secondary Plan** shall pay the lesser of:

i. the difference between the amount of the billed charges for the **Allowable Charges** and the amount paid by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

The covered person shall only be liable for the **deductible**, **coinsurance** or **copayment** under the **Secondary Plan** if the covered person has no liability for **deductible**, **coinsurance** or **copayment** under the **Primary Plan** and the total payments by both the **Primary Plan** and the **Secondary Plan** are less than the providers billed charges. In no event shall the covered person be responsible for any payment in excess of the **deductible**, **coinsurance** or **copayment** of the **Secondary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan
If the provider is a **Network Provider** in the **Primary Plan**, the **Allowable Expense** considered by the **Secondary Plan** shall be the fee schedule of the **Primary Plan**. The **Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Fee Schedule Plan and Secondary Plan is Recognized Charge Plan or Fee Schedule Plan
If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of **urgent care** or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as **urgent care** or emergency care, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or Recognized Charge Plan
If the covered person receives services or supplies from a provider who is a **Network Provider** of both the **Primary Plan and the Secondary Plan, the Secondary Plan** shall pay the lesser of:

i. the amount of any **deductible**, **coinsurance** or **copayment** required by the **Primary Plan**; or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

Primary Plan is Capitation Plan or Fee Schedule Plan or Recognized Charge Plan and Secondary Plan is Capitation Plan
If the covered person receives services or supplies from a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall be liable to pay the capitation to the **Network Provider** and shall not be liable to pay the **deductible**, **coinsurance** or **copayment** imposed by the **Primary Plan**. The covered person shall not be liable to pay any **deductible**, **coinsurance** or **copayment** of either the **Primary Plan** or the **Secondary Plan**.

Primary Plan is an HMO and Secondary Plan is an HMO
If the **Primary Plan** is an HMO plan that does not allow for the use of non-network providers except in the event of urgent or emergency care and the service or supply the covered person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is a **Network Provider** of the **Secondary Plan**, the **Secondary Plan** shall pay benefits as if it were the **Primary Plan**.

Primary and Secondary Plans are Reasonable Charge Plans
The **Secondary Plan** shall pay the lesser of:

i. the difference between the amount of the billed charges and the amount paid by the **Primary Plan;** or
ii. the amount the **Secondary Plan** would have paid if it had been the **Primary Plan**.

When the benefits of the **Secondary Plan** are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the **Plan**.

Effects of Automobile Plans for Automobile Related Injuries

This section will be used to determine a **covered person**'s benefits under this **Plan** when expenses are incurred as a result of an automobile related **injury**.

Definitions

"**Automobile Related Injury**" means bodily **Injury** sustained by a **covered person** as a result of an accident:

iii. while occupying, entering, leaving or using an automobile; or
iv. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"**Allowable Expense**" means a **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:

a) the **Policy**;
b) **PIP**; or
c) **OSAIC**.

"**Eligible Expense**" means that portion of expense incurred for treatment of an **injury** which is covered under this **Plan** without application of Cash **Deductibles** and **Copayments**, if any or **Coinsurance**.

"**Out-of-State Automobile Insurance Coverage**" or "**OSAIC**" means any coverage for medical expenses under an automobile insurance policy other than **PIP**. **OSAIC** includes automobile insurance policies issued in another state or jurisdiction.

"**PIP**" means personal **injury** protection coverage provided as part of an automobile insurance policy issued in New Jersey. **PIP** refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The **Policy** provides secondary coverage to **PIP** unless health coverage has been elected as primary coverage by or for the **covered person** under this **Plan**. This election is made by the named insured under a **PIP** policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. The **Policy** may be primary for one **covered person** but not for another if the person has separate automobile policies and has made different selections regarding primary of health coverage.

The **Policy** is secondary to **OSAIC** unless the **OSAIC** contains provisions which make it secondary or excess to the policyholder's plan. In that case this **Plan** will be primary.

If there is a dispute as to which **policy** is primary, this **Plan** will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC

If this **Plan** is primary to **PIP** or **OSAIC** it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this **Plan** will apply if:

a) the **Covered Person** is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if secondary to PIP or OSAIC

If this **Plan** is secondary to **PIP** or **OSAIC** the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after **PIP** or **OSAIC** has provided coverage after applying Cash **Deductibles** and **Copayments**, or
b) the benefits that would have been paid if this **Plan** had been primary.

Medicare

If this **Plan** supplements coverage under **Medicare** it can be primary to automobile insurance only to the extent that **Medicare** is primary to automobile insurance.

When You Have Medicare Coverage

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

You are eligible for **Medicare**:

- by reason of age, disability; or
- End Stage Renal Disease.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the **primary payor**, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the **secondary payor**, and pays benefits after **Medicare**.

Which Plan Pays First

When a Covered Person Becomes Eligible for Medicare.
The plan is the **Primary Plan** when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the **Primary Plan** for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the **Secondary Plan** in all other circumstances. Benefits will be payable in accordance with the *Rules for the Order of Benefits Determination* within this Coordination of Benefits section.

If **Medicare** is the **Primary Plan** and if **This Plan** is the **Secondary Plan**, and you are eligible for **Medicar**e but refuse it, drop it, or fail to make proper request for it, **Aetna** will estimate the **Medicare** payment as if you were covered by **Medicare**, and as if **Medicare** was the **Primary Plan** and **Aetna** will pay as if it was the **Secondary Plan**.

How Coordination With Medicare Works

The **plan** pays benefits first when it is the **Primary Plan**. You may then submit your claim to **Medicare** for consideration. When **Medicar**e is the Primary Plan, you must first submit your health care expenses to **Medicare**. You may then submit the expense to **Aetna** for consideration.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

General Provisions *(GR-9N-32-005-02)*

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Conditions that are related to the Complications of Pregnancy will be covered under this plan. See your *Schedule of Benefits* for more information.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you. **Aetna** will also have the right and opportunity to make an autopsy, in case of death, where it is not prohibited by law.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by calling **Aetna**'s toll-free Member Service telephone.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments *(GR-9N-32-005-05-NJ)*

An assignment is the transfer of your rights under the group policy to a person you name.

When a covered person submits a claim and they assign their right to receive reimbursement for covered **Medically Necessary** services to an out of network provider, **Aetna** is required to pay benefits in line with the assignment of benefits by remitting payment directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as a joint payee, with signature lines for each of the payees.

Any payment made solely to the covered person rather than the health care provider under these circumstance shall be considered unpaid, and unless remitted to the health care provider within the time frames established by New Jersey Law, shall be considered overdue and subject to an interest charge as provided in that act.

All coverage may be assigned only with the written consent of **Aetna**.

Misstatements

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of a written statement signed by the person insured is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of the policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding the Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Recovery of Overpayments *(GR-9N-32-015-01 NJ)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right; within the following guidelines:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, **Aetna** will not seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. **Aetna** will not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, **Aetna** will provide written documentation that identifies the error made in the processing or payment of the claim that justifies the reimbursement request. **Aetna** will not base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and **Aetna** has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

In seeking reimbursement for the overpayment from the health care provider, except in cases where the overpayment to the health care provider is a result of fraud, **Aetna** shall not collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal are exhausted; or
(iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

Aetna may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal have been exhausted if **Aetna** submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile your bill.

If **Aetna** has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, **Aetna** may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims *(GR-9N-32-020-01 NJ)*

Written notice of **illness** or of **injury** must be submitted to **Aetna** within 20 days after the date in which the **illness** or **injury** occurred. Any necessary claim forms required for filing a claim will be furnished by **Aetna** upon receipt of written request. Failure to give notice of loss shall not invalidate nor reduce any claim if notice was given as soon as reasonably possible. Written proof of loss must be furnished to **Aetna** within 90 days after the date of such loss. If the person making claim does not receive the requested claim forms before the expiration of 15 days after **Aetna** receives notice of any claim, the person making such claim shall be deemed to have complied with the requirements of the plan as to proof of loss upon submitting within the time fixed within the plan for filing proof of loss, written proof covering the **occurrence**, character and extent of the loss for which claim is made.

Accident and Health expense insurance claims filed by a provider on behalf of you, the provider shall file with us the claim within 60 days of the last date of service or course of treatment. For **Accident** and Health expense insurance claims in which you have assigned your benefits to the provider, the provider shall file the claim within 180 days of the last date of service of a course of treatment. In the event the **provider** does not file the claim within 180 days of the last date of service of a course of treatment, **Aetna** reserves the right to deny or dispute the claim and the **provider** shall be prohibited from seeking payment in whole or in part directly from the member covered person.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Failure to furnish such proof within such time shall not reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Payment of Benefits *(GR-9N-32-025-02)*

Health

(1) Upon satisfactory proof of loss, **Aetna** will remit payment for claims submitted by you or your health care provider for **covered expenses** no later than 30 calendar days following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program, whichever is earlier, if the claim is submitted by electronic means and no later than 40 calendar days following receipt if the claim in submitted by other than electronic means, if:
   a) the health care provider is eligible at the date of service;
   b) the person who received the health care service was covered on the date of service;
   c) the claim is for a service or supply covered under this policy;
   d) the claim is submitted with all the information requested by **Aetna** on the claim form or in other instructions that were distributed in advance to the provider or member in accordance with New Jersey laws; and
   e) A**etna** has no reason to believe that the claim has been submitted fraudulently.

(2) If all or a portion of the claim is not paid within the timeframes provide above because:
   a) The claim submission is incomplete because the required substantiating documentation has not been submitted to **Aetna**;
   b) The diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
   c) **Aetna** disputes the amount claimed; or
   d) There is strong evidence of fraud by the provider and **Aetna** has initiated an investigation into the suspected fraud, **Aetna** shall notify the provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
      i) The claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
      ii) The claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;

iii) **Aetna** disputes the amount claimed in whole or in part with a statement as to the basis of what dispute; or

iv) **Aetna** finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with **Aetna**'s fraud prevention plan, or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, **Aetna** shall electronically notify the provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by **Aetna** in accordance with the time limit established in paragraph (1) of this subsection.

(5) **Aetna** shall acknowledge receipt of a claim submitted by electronic means from a health care provider no later than two working days following receipt of the transmission of the claim.

(6) If **Aetna** has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan, or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(7) Payment of an eligible claim pursuant to paragraphs (1) and (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by **Aetna** of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by **Aetna** on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by **Aetna** of the required documentation or information or modification of an initial submission.

If payment is withheld on all or a portion of a claim by **Aetna** pursuant to paragraph (2) or (3) of this subsection and the covered person and the provider are not notified within the time frames provided for in those paragraphs, the claim shall be deemed to be overdue.

Any overdue payment shall bear simple interest at the rate of 12% per annum. **Aetna** shall pay the interest to the provider at the time the overdue payment is made. The amount of interest paid to a provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the premium.

Acknowledgement of receipt of claims:

(a) **Aetna** shall acknowledge receipt of all claims. The acknowledgement shall include the date **Aetna** received the claim.

1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which **Aetna** received the claim.
2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If **Aetna** remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If **Aetna** offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.
(d) If **Aetna** offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

All benefits are payable to you, except that, at the request of the employee or covered person or in the event of his/her death, payment of benefits to the extent of expenses incurred on account of hospitalization may be made by **Aetna** to the hospital and except that the group policy may provide that all or any portion of any benefits on account of hospital, nursing, medical or surgical services may, at **Aetna**'s option, be paid directly to the hospital or person rendering such services provided, further, that authorization for any such payments have been obtained from the covered person.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** or licensed health professional (**network services or supplies**), the **network provider** will take care of filing claims, except that at the patient's option, the patient may file the claim. When you seek care on your own (**out-of-network services and supplies**), you or the **out-of-network provider** is responsible for filing the claim.

Records of Expenses *(GR-9N-32-030-02 NJ)*

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans *(GR-9N 32-035-01)*

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business *(GR-9N 32-40 03 NJ)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

health coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence.*

Rescission of Coverage *(GR-9N-32-005-06-NJ)*

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

Appeals Procedure *(GR-9N-32-050-01 NJ)*

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit. As to medical and **prescription drug** claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the **group policy** or the **booklet-certificate**.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

Appeal: An written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

Emergency Care Claim: Any claim for a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the women or unborn child. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another **hospital** before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

External Review: A review of an **adverse benefit determination** or a **final internal adverse benefit determination** by an Independent Utilization Review Organization (IURO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The IURO must have expertise in the problem or question involved.

Final Internal Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the completion of the internal **appeal** process or an **adverse benefit determination** with respect to which the internal **appeal** process has been exhausted under the deemed exhaustion rules.**Pre-Service Claim**: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "**pre-service claim**."

Urgent Care Claim: Any claim for medical care or treatment (which shall include all situations in which the covered person is confined in an inpatient facility) with respect to which the application of the time periods for making non-urgent care determinations could

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.
- An **urgent care claim** could be for any condition if in the opinion of a physician with knowledge of the claimant's medical condition would cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care; or
- in the case of an individual acting on behalf of the plan applying the judgment of a prudent layperson who possess an average knowledge of health and medicine determines urgent care is needed; or
- for a non-life threatening condition that requires care by a provider within 24 hours.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, **Aetna** prior to issuing a **final internal adverse benefit determination,** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue, free of charge. This will be provided to you as soon as possible and sufficiently in advance of the date on which the notice of the **final internal adverse benefit determination** is required to be provided so that you, your authorized representative, and/or **provider** may respond prior to that date.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below As to medical and **prescription drug** claims only, if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**. You, your authorized representative, or a **provider** acting on your behalf must be given written notice of any **adverse benefit determination** within two business days of the **adverse benefit determination**. The written notice must include an explanation of the Appeal Process.

Urgent or Emergency Care Claims

Aetna will notify you of an **urgent or emergency care claim** decision whether adverse or not as soon as possible, but not later than72 hours after the claim is made.

If more information is needed to make an **urgent or emergency care claim** decision, **Aetna** will notify the claimant or an authorized representative (which includes health care professionals with knowledge of a claimant's medical condition) within 72 hours of receipt of the claim. The claimant or authorized representative has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant or authorized representative within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the claimant or authorized representative to provide **Aetna** with the information.

Pre-Service Claims

Aetna will notify you of a **pre-service claim** decision as soon as possible, but not later than 15 calendar days or sooner if the medical exigencies dictate, upon request, of any determination to deny coverage or authorization of services or payment of benefits after the claim is made. The notice will include an explanation of the **appeal** process.

Post-Service Claims

Aetna will notify you of a **post-service claim** decision as soon as possible, but not later than 30 calendar days after the claim is made or the time limit established by Medicare, if earlier, after the post-service claim is made if the claim is submitted electronically, or 40 days, if submitted by a means other than electronic. **Aetna** may determine that due to matters beyond its control a claim may require special treatment. If so, **Aetna** will notify you in writing including the reason for delay within 30 days. If special treatment is needed because Aetna needs additional information to make a decision, the notice shall specifically describe the required information. In the event that payment is withheld on all or a portion of the claim, because the claim required special treatment, a claim determination will be made on the withheld portion no later than 30 calendar days or the time limit established by Medicare, if earlier, following receipt of the required documentation for claims submitted by electronic means and no later than 40 days following receipt of the required documentation for claims submitted other than electronically.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **emergency** or **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided within the time frame applicable to (1) an **urgent care claim** (if the care is urgent) or (2) a **pre-service** or **post-service** claim (if the care is not urgent or has been completed).

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the **final internal appeal decision**, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

If **Aetna** makes a claim determination to reduce or terminate a previously approved course of treatment while the treatment or services are ongoing, you (or a **provider** on your behalf) may request an expedited **appeal,** and **Aetna** will handle such a request as a Level One **appeal** or an **urgent care claim** (see **appeals** of **adverse benefit determinations**). **Aetna** will not deny coverage based on **medical necessity** for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by you or the **provider**.

Rescission of Coverage

As to medical and **prescription drug** claims only, **Aetna** will notify you of a **rescission of coverage** (termination of coverage back to the original effective date) with a 30 day advance written notification to allow you to **appeal.**

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **network provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal.** A **final internal adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The Employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered. You have the option to provide **Aetna** with additional information about your **appeal**; however, you are not required to provide additional information in order to have your claim decision reviewed.

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal – Group Health Claims involving UR Claims

A review of a Level One **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**. An **urgent care claim appeal** may be submitted orally or in writing.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 10 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 10 calendar days of receipt of the request for an **appeal**.

Level One Appeal – Group Health Claims involving non-UR Claims

Rescission of Coverage
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claim
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Level Two Appeal - Group Health Claims for UR Claims

If **Aetna** upholds an **adverse benefit determination** at the Level One **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons or in situations where the denial is based on characterizing the service as dental or as cosmetic, you or your authorized representative have the right to file a Level Two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

Review of a Level Two **appeal** of an **adverse benefit determination** of an **urgent care claim, a pre-service claim, or a post-service claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**. A Level Two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the **Aetna** Appeal Committee.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for a Level Two **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **appeal**.

Level Two Appeal – Group Health Claims for non-UR Claims

Rescission of Coverage
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Post-Service Claim
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Please Read:

You may contact the New Jersey Department of Banking and Insurance to file a **complaint/appeal** or request an investigation of a **complaint/appeal** at any time. You are not required to exhaust the Level One and Level Two **appeals** process before contacting the New Jersey Department of Banking and Insurance.

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P. O. Box 329
Trenton, NJ 08625-0329

Before filing a Level One or Two **appeal** with **Aetna**, you or your authorized representative, may also contact the New Jersey Office of Insurance Claims Ombudsman if you are dissatisfied with the decision reached by **Aetna.**

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Phone: 800-446-7467
Email: ombudsman@dobi.state.nj.us

Exhaustion of Process

Under certain circumstances you may seek simultaneous review through the internal **appeal** procedure and **external review** processes—these include **urgent care claims** and situations where you are receiving an ongoing course of treatment. When you seek a simultaneous expedited **external review**, the **appeal** process will be deemed to have been exhausted.

Important Note:

If **Aetna** waives the requirement to **appeal,** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, or you have applied for an expedited review at the same time as applying for an expedited internal **appeal**, you are considered to have exhausted the **appeal** requirements and may proceed with **external review** or any of the actions mentioned below. There are limits, though, on what sends a claim or an **appeal** straight to an **external review**. Your claim or internal **appeal** will not go straight to **external review** if:

- a rule violation was minor and isn't likely to influences a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna.**

You, your authorized representative, or a **provider** acting on your behalf may request a written explanation of the violation from **Aetna** and **Aetna** must provide such explanation of the violation within ten days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal Claim and Appeal Process to be deemed exhausted.

If an external reviewer or a court rejects your request, your authorized representative's request, or **provider's** request for immediate review on the basis that **Aetna** met the standards for the exception set forth in this section, you, your authorized representative, or provider has the right to resubmit and pursue the internal **appeal** of the claim. An **appeal** should be made within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed ten (10) days. **Aetna** must provide notice of the opportunity to resubmit and pursue the internal **appeal**. The time period for submitting the **appeal** begins to run when you, your authorized representative, or **provide**r receives notice.

Unless serious or significant harm has occurred or will imminently occur to you, you must exhaust an **appeal** through the Independent Health Care Appeals Program before you establish any litigation, arbitration, or administrative proceeding regarding an alleged breach of the **group policy** terms by **Aetna Life Insurance Company**; or any matter within the scope of the **appeal** procedure.

External Review *(GR-9N-32-051-01 NJ)*

You may receive an **adverse benefit determination** or **final internal adverse benefit determination**.

In either of these situations, you may request an **external review** if you or your **provider** disagrees with **Aetna's** decision in accordance with the procedures set forth below for **final internal adverse benefit determinations** based on **medical necessity**, appropriateness, health care setting, level of care or effectiveness of a covered benefit. An **external review** is a review by an Independent Utilization Review Organization (IURO) assigned by the New Jersey Department of Banking and Insurance made up of **physicians** or other appropriate health care providers. The IURO must have expertise in the problem or question involved.

To request an **external review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final internal adverse benefit determination** notice by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **medically necessary** or was **experimental or investigational**.
- You have exhausted the applicable internal **appeal** processes or you qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final internal adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **external review**, including a copy of the *Request for External Review Form*.

You must submit the *Request for External Review* Form with a general release executed by you for all medical records pertinent to the **appeal** within 123 calendar days of the date you received the **adverse benefit determination** or **final internal adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request. The request shall be mailed to:

New Jersey Department of Banking and Insurance
Office of Managed Care
Consumer Protection Services
P.O. Box 329
Courier: 20 West State Street
Trenton, New Jersey 08625-0329

The fee for filing an appeal shall be $25.00, payable by check or money order to the New Jersey Department of Banking and Insurance. The filing fee is payable by you. The filing fee shall be refunded if the **final internal adverse benefit determination** is reversed by the IURO. Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by you through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, New Jersey Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance. Annual filing fees for any one covered person shall not exceed $75.00.

Upon receipt of the **appeal**, together with the executed release and the appropriate fee, the New Jersey Department of Banking and Insurance shall immediately assign the **appeal** to an IURO.

Upon receipt of the request for **appeal** from the New Jersey Department of Banking and Insurance, the IURO shall conduct a preliminary review of the **appeal** and accept it for processing if it determines that:

i. The individual was or is covered by **Aetna**.
ii. The service which is the subject of the **complaint** or **appeal** reasonably appears to be a covered benefit under the plan.
iii. You have fully complied with both the Level One and Level Two **appeal** processes unless **Aetna** fails to comply with any of the deadlines for completion of the Internal Appeals Process. This will not apply if **Aetna's** violation does not cause and is not likely to cause, prejudice, or harm to the covered person or provider. **Aetna** must demonstrate that the violation was for good cause or due to matters beyond **Aetna's** control and that the violation occurred in the context of an ongoing good faith exchange between **Aetna**, you, your authorized representative, and/or **provider** acting on your behalf and is not reflective of a pattern of non-compliance by **Aetna.**
iv. You have provided all information required by the IURO and the New Jersey Department of Banking and Insurance to make the preliminary determination including the **appeal** form and a copy of any information provided by **Aetna** regarding its decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from **Aetna** and any other relevant health care provider.
v. You have remitted the required fee to the New Jersey Department of Banking and Insurance.

Upon completion of the preliminary review, the IURO shall immediately notify you and/or **provider** in writing as to whether the **appeal** has been accepted for processing and if not so accepted, the reasons therefore.

Upon acceptance of the **appeal** for processing, the IURO shall conduct a full review to determine whether, you were deprived of **medically necessary** covered benefits. In reaching this determination, the IURO shall take into consideration all pertinent medical records, consulting **physician** reports, and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by **Aetna**.

The full review referenced above shall refer all cases for review to an expert **physician** in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the **appeal**. All final decisions of the IURO shall be approved by the medical director of the IURO who shall be a **physician** licensed to practice in New Jersey.

The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 45 calendar days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO shall, prior to the conclusion of the preliminary review, provide written notice to you, to the New Jersey Department of Banking and Insurance, and to **Aetna** setting forth the status of its review and the specific reasons for the delay.

If the IURO determines that you were deprived of **medically necessary** covered benefits, the IURO shall recommend to you, **Aetna**, and the New Jersey Department of Banking and Insurance, the appropriate covered health care services you should receive.

Once the review is complete, **Aetna** will abide by the decision of the IURO except to the extent that other remedies are available to either party under State or Federal law. **Aetna** shall provide benefits (including payment on the claim) pursuant to the IURO's determination without delay even if **Aetna** plans to seek judicial review of the external review decision (unless there is a judicial decision stating otherwise). Within 10 business days of the receipt of the decision of the IURO, **Aetna** must submit a written report to the IURO, you, your authorized representative, or the **provider** who made the **appeal** acting on your behalf with your consent and the Department of Banking and Insurance indicating how **Aetna** will implement the IURO's determination.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- endanger your health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

If the **appeal** involves care for an urgent or emergency case, an admission, availability of care, continued stay, health care services for which the covered person received emergency services but has not been discharged from a facility or involves a medical condition for which standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the IURO must complete its review within no more than 48 hours following its receipt of the **appeal.**

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IURO to New Jersey's Department of Banking and Insurance. **Aetna** is responsible for the cost of sending its information to the IURO.

For more information about the **external review** process, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-9N-34-005-04 NJ)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-005-05)*

Accident *(GR-9N-34-005-04 NJ)*

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Autism/Autism Spectrum Disorder

This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder - Not Otherwise Specified.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B *(GR-9N-34-010-01)*

Behavioral Health Provider/Practitioner

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **non biologically-based** or **biologically-based mental illnesses** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;

- Addictionologists; and
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Biologically-Based Mental Illnesses

A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the **illness**, including but not limited to:

- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Paranoia and other psychotic disorders.
- Pervasive developmental disorder (including Autism).
- Schizo-affective disorder.
- Schizophrenia.

Coverage of such illness will be subject to the same terms and conditions as other illnesses.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug

A **prescription drug** as determined by the Food and Drug Administration (FDA) and it protected by the trademark registration of the pharmaceutical company which produces them.

C *(GR-9N 34-015 02)*

Civil Union Partner
A person who has established a civil union as defined by New Jersey State Law. If applicable, any references under this Booklet-Certificate made to "marriage", "husband", "wife", "family", "immediate family", "dependent", "next of kin", "widow", "widower", "widowed" or another word which in a specific context denotes a marital or spousal relationship, the same shall include a **civil union partner**. In addition, a same sex relationship entered into outside of New Jersey which is valid under the law of another state or foreign nation that provides substantially all of the rights and benefits of marriage, shall be treated as a **civil union partner** under New Jersey law.

Coinsurance
Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage of **coinsurance** may vary by the type of expense. Please refer to the *Schedule of Benefits* for specific information on the applicable **coinsurance** percentage.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies whose primary purpose is to alter, improve or enhance appearance.

Covered Expenses
Charges associated with medical, dental, vision or hearing services and supplies shown as covered under this booklet-certificate.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;

- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D *(GR-9N 34-020 01)*

Day Care Treatment
A **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment**.

Deductible
The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification
The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Developmental Disability or Developmentally Disabled
This means a severe, chronic disability that:

- is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- is manifested before the Covered Person:
  - attains age 22 for purpose of the Diagnosis and Treatment of Autism and other Developmental Disabilities provision; or
  - attains age 26 for all other provisions;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity; self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
- reflects the Covered Persons need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spinal-bifida and other neurological impairments where the above criteria is met.

Directory
A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E *(GR-9N 34-025 02)*

E-visit
An **E-visit** is an online internet consultation between a **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

Effective Treatment of a Mental Disorder
This is a program that:

- Is prescribed; and supervised; by a **physician**; and
- Is for a **mental disorder** that can be favorably changed.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition
A medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another **hospital** before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

  that states that it is **experimental or investigational**, or for research purposes.

G *(GR-9N 34-035 01)*

Generic Prescription Drug

A therapeutically equivalent **prescription drug**, as determined by the Food and Drug Administration (FDA) and which is identical to the **brand-name prescription drug** in strength or concentration, dosage form and route of administration.

H *(GR-9N 34-040 02)*

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.
- Certified under Title XVIII of the Social Security Act or a proprietary agency licensed by the Commissioner of Health.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. All care plans shall be established within 14 days following the commencement of home health care. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

However, for purposes of **Hospice Care** coverage, the term **hospital** will include the portion of a **hospital** that provides hospice care.

Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I *(GR-9N 34-045 02) (GR-9N 34-045 01)*

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a covered person who is unable to conceive or produce conception after:

- a person is not able to impregnate another person;
- a person is not able to conceive after 1, 2 year(s) of unprotected intercourse, if the female partner is under 35 years of age; or conceive after 6 months, 1 year of unprotected intercourse if the female partner is 35 years of age or older;
- one of the partners is determined to be medically sterile; or
- a person is not able to carry a pregnancy to live birth.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by any person.
- An act or event must be definite as to time and place.

J *(GR-9N 34-050 01)*

Jaw Joint Disorder *(GR-9N 34-050 01)*
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L *(GR-9N 34-055 01)*

Late Enrollee
This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

L.P.N.
A licensed practical or vocational nurse.

M *(GR-9N-34-065-03 NJ)*

Mail Order Pharmacy
An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit

Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **coinsurance, copayments** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you meet the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year.

The following expenses do not apply toward your **maximum out-of-pocket limits**:

- Charges over the **recognized charge**,
- Non-**covered expenses**, and
- Expenses that are not paid or precert benefit reductions made because a **precertification** is needed for the services or supply was not obtained from **Aetna**.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Morbid Obesity

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N *(GR-9N-34-070-04 NJ)*

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider

A health care provider or **pharmacy** who has contracted to furnish services or supplies; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or recommended by your **PCP**.

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Biologically-Based Mental Illness

An **illness** which manifests symptoms that are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the **illness** is not biologically-based.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not arise out of (or in the course of) any work related activity you perform for pay or profit, or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not arise from any work related activity you perform for pay or profit or result in any abnormal condition or disorder caused by exposure to environmental factors associated with employment or self-employment.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O *(GR-9N-34-075-04 NJ)*

Occupational Injury or Occupational Illness
An **injury** or **illness** that arises out of (or in the course of) any activity or work that results in a condition from exposure in a workplace through your employment or self-employment. A secondary **illness** or **injury** that results from the original **occupational illness or occupational injury** will be considered an **occupational illness or occupational injury** under this plan.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment *(GR-9N-34-075-04 NJ)*
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- Furnished by an **out-of-network provider**; or
- Not furnished or recommended by your **PCP**.

Out-of-Network, Non-Participating, Non-Preferred Provider
A health care provider or **pharmacy** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge**.

P *(GR-9N-34-080-05 NJ)*

Partial Confinement Treatment
A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, substance abuse, or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse, a non-biologically-based illness or biologically-based mental illness condition;
- For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Physician also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst; and
- A physician is not you or related to you.

Precertification, Precertify, Preauthorization
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or certain **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Preventive Care or Preventive Services
Preventive Care or Services means services or supplies that are not provided in connection with the treatment of injury or illness. Preventive Care includes, but is not limited to: routine physical examinations including related laboratory and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital
This is an institution that meets all of the following requirements:

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse, non biologically based mental illness or biologically-based **mental illnesses**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R *(GR-9N-34-090-01 NJ)*

Recognized Charge
The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  – 300% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.
- For inpatient and outpatient charges of **hospitals** and other facilities:
  – 300% of the Medicare Allowable Rate;
  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Medicare Allowable Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Medicare Allowable Rates: These are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. **Aetna** updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

Important Note
Aetna periodically updates its systems with changes made to the Medicare Allowable Rates.
What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Alcoholism and Substance Abuse)
This is an institution that meets all of the following requirements:

- Has, on site, licensed **behavioral health provider**, medical or alcoholism [or drug abuse] health care providers 24 hours per day.
- Provides a comprehensive patient assessment.
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions, and to obtain needed services either on-site or externally.
- Has 24 hour supervision with evidence of close and frequent observation.
- Has medical treatment available, actively supervised by an attending **physician** or **psychiatric physician**.
- Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs.
- Offers group therapy sessions.
- Has the ability to involve family and other support systems in therapy.
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Provides active discharge planning initiated upon admission to the program.
- Can make **referrals** to, or has a connection with appropriate alcoholism and drug abuse programs during residential treatment, and following discharge.
- Meets any applicable licensing standards established by the jurisdiction in which it is located.
- Charges patients for its services.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Non Biologically-Based Mental Illnesses, Biologically-Based Mental Illnesses)

This is an institution that meets all of the following requirements:

- Has, on site, licensed **behavioral health providers** 24 hours per day.
- Provides a comprehensive patient assessment.
- Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs.
- Offers group therapy sessions.
- Has the ability to involve family and other support systems in therapy.
- Provides access to at least weekly sessions with a **psychiatric physician** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Is managed by a licensed **behavioral health provider** who functions under the direction and supervision of a **psychiatric physician**.
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Provides active discharge planning initiated upon admission to the program. (This is not applicable to inpatient treatment of **Biologically Based Mental Illness**.)
- Meets any applicable licensing standards established by the jurisdiction in which it is located.
- Charges patients for its services.

R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S *(GR-9N 34-095-05)*

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **non biologically-based mental illnesses or biologically-based mental illnesses**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **non biologically-based mental illnesses** or **biologically-based mental illnesses**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander;
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients;
- Written procedures for such a transfer must be displayed and the staff must be aware of them;
- Keeps a medical record on each patient.

T *(GR-9N 34-100-02)*

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

U *(GR-9N-34-105-01)*

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care

A non-life-threatening condition that requires care by a provider within 24 hours.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

W *(GR-9N 34-110 01)*

Walk-in Clinic

Walk-in clinic is a free-standing health care facility. It is an alternative to a **physician's** office visit for treatment of unscheduled, non-emergency **illnesses** and **injuries** and the administration of routine immunizations. It is not an alternative for emergency room services for the ongoing care provided by a **physician**. Neither an emergency room nor the outpatient department of a **hospital** shall be considered a **walk-in clinic**.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Additional Information Provided by

School for Children with Hidden Intelligence

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
School for Children with Hidden Intelligence Employer Benefits Plan

Employer Identification Number:
22-3301312

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
School for Children with Hidden Intelligence
Attn: Ahuva P. Gruen, Plan Administrator
345 Oak Street
Lakewood, NJ 08701
Telephone Number: 732-886-0900

Agent For Service of Legal Process:
School for Children with Hidden Intelligence
Attn: Ahuva P. Gruen, Plan Administrator
345 Oak Street
Lakewood, NJ 08701
Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by Ahuva P. Gruen, Plan Administrator.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:
   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan at the Preferred Care level benefits only. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:

      - Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child's primary care provider, if the provider is available to accept your child.

   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.

   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non participating provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.

2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.

   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.

d. The eligibility rules for children have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or solely dependent upon you for support will not apply. **Please Note**: For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent's plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call the Member Services number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:
   - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
     - Screening and counseling services, such as:
       - Interpersonal and domestic violence;
       - Sexually transmitted diseases; and
       - Human Immune Deficiency Virus (HIV) infections.
     - Screening for gestational diabetes.
     - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years.
   - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
   - Preventive counseling visits and/or risk factor reduction intervention;
   - Medical nutrition therapy;
   - Nutritional counseling; and
   - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

   Benefits under your plan may be subject to visit maximums.

4. Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

   Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:
   - Preventive counseling visits;
   - Treatment visits; and
   - Class visits.

   Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

   The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

   Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:
   - FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
   - Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
   - Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
   - FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

   Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

   The drug list is subject to change. Visit "Medication Search" on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

    - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
    - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
        i. aspirin for men and women age 45 and over;
        ii. folic acid for women planning or capable of pregnancy;
        iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
        iv. vitamin D supplementation for men and women age 65 and older;
        v. fluoride supplementation for children from age 6 months through age 5;
        vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
        vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed $6,350 per person and $12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
    a. not include out-of-pocket maximums; or
    b. have separate maximums from the medical plan up to these same amounts; or
    c. have maximums that are combined with the medical plan up to these same amounts.

3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.